DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Long Term Acute Care
Contracted Facilities
Managed Care Plans
Regional Administrators
CSO Administrators

Memorandum No. 00-42 MAA
Issued: August 15, 2000

From: James C. Wilson, Assistant Secretary
Medical Assistance Administration

Subject: **Update to the Billing Procedures for the Long Term Acute Care (LTAC) Program**

- **Retroactive to dates of service on and after October 1, 1998,** the Medical Assistance Administration (MAA) is paying for ancillary services not included in the per diem rate. This numbered memorandum contains the revenue codes providers need to use when billing for these ancillary services.
- **Retroactive to dates of service on and after April 1, 2000,** MAA updated the billing procedures for the LTAC Program. This numbered memorandum explains the updates.

Ancillary Revenue Codes

- Retroactive to dates of service on and after October 1, 1998, MAA removed the following revenue codes from inclusion in the per diem rate and began paying separately for these codes using the RCC payment method. For inpatient services, providers must bill the following revenue codes using the UB-92 claim form:

Revenue Code	Description
250	Pharmacy-General Classification to include prescription drugs, TPN/IV therapy and Epogen/Neupogen-which exceeds $200 per day
320	Radiology-General Classification
340	Nuclear Medicine-General Classification
350	CT (Computered Tomographic) Scan-General Classification
360	Operating Room Services-General Classification
370	Anesthesia-General Classification
390	Blood Storage and Processing-General Classification
391	Blood Storage and Processing-Blood Administration
402	Other Imaging Services-Ultrasound
460	Pulmonary Function-General Classification
710	Recovery Room-General Classification
730	EKG/ECG-General Classification
921	Other Diagnostic Services-Peripheral Vascular Lab

☞ **Note:** Do not rebill your claims to receive these new reimbursement amounts. MAA will automatically adjust all paid claims with dates of service on and after November 1, 1999.

- A vendor, other than the hospital, who provides specialty beds, renal dialysis, hemodialysis, and all other authorized services/equipment, must bill MAA directly.

- MAA pays only for those pharmacy expenses in excess of $200 per day. Bill revenue code 250 showing total charges in form locator 47 and the first $200 per day in form locator 48 (Noncovered Charges).

- Use revenue code 169 to bill services as administrative days for patients who do not meet inpatient criteria or who are waiting for discharge placement.

New Billing Procedures

- MAA has changed the billing function of revenue code 128. Revenue code 128 now bills your usual and customary charge rather than your contract per diem rate. MAA uses this revenue code as a tracking device for the relationship between your per diem rate and your charges. Enter your usual and customary charges under form locators:

  ✓ 47 (Total Charges), and
  ✓ 48 (Noncovered Charges).

- Use revenue code 100 to bill your contracted per diem rate by entering the amount in form locator 47 (Total Charges*)*. Enter LT in form locator 32 (Occurrence Code).

- Total charges must be equal to the sum of all the revenue codes entered.

☞ **Note:** Continue to use revenue code 128 at the contract rate to bill for dates of service prior to April 1, 2000. The revenue codes used to bill for ancillary charges are not affected by these new billing procedures.